

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN470ASC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2010
NAME OF PROVIDER OR SUPPLIER DIGESTIVE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5250 KIETZKE LANE RENO, NV 89511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	<p>INITIAL COMMENTS</p> <p>Surveyor: 13812 This Statement of Deficiencies was generated as a result of a State Health Licensure focused survey conducted in your facility on 1/11/10 and finalized on 1/11/10, in accordance with Nevada Administrative Code, Chapter 449, Surgical Centers for Ambulatory Patients.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	A 00		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE